DIVISION OF MEDICAL SERVICES
PROVIDER BULLETIN

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OPTICAL BULLETIN

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OPTICAL PROGRAM

Effective September 1, 2005 Optical Program benefits will change due to the passage of Senate Bill 539 by the 93rd General Assembly. Lenses and frames for adults in the Medicaid Eligibility codes 01, 04, 05, 10, 11, 13, 19, 21, 24, 26, 83, and 84 are not covered. Eye examinations for refractive error will be limited to one exam every two years. Services (excluding frames and lenses) related to trauma or treatment of a disease/medical condition are covered.

Frames or lenses ordered or fabricated prior to September 1, 2005 and placement occurs on or after September 1, 2005, may be covered under the custom-made item policy. Refer to section 13.12 of the Optical Manual for further information on the custom-made item policy.

OPTICAL PROCEDURE CODES

Effective August 1, 2005 Certificate of Medical Necessity (MN) and Invoice of Cost (IOC) have been removed from some Optical procedure codes.

The Certificate of Medical Necessity (MN) is no longer required to be submitted with the claim form if the code has the indicator “MNF” (Medical Necessity on File) under the restrictions column. A “MNF” under the restrictions column indicates a certificate of medical necessity must be completed and maintained in the provider’s records.

Manual pricing and invoice of cost have been removed where the Division of Medical Services (DMS) has determined a Medicaid Maximum Allowable Amount for the procedure code. The affected codes are listed below:

Procedure Code	Modifier	Description	Restrictions	Medicaid Maximum Allowed Amount
68899		Unlisted procedure, lacrimal system	NONE	$35.00
92070		Fitting of contact lens for treatment of disease including supply of lens	MNF	$80.00
92265		Needle oculoelectromyography 1/more extra ocular muscles 1/both eyes with interpretation and report	NONE	$15.00
S0592		Comprehensive contact lens, evaluation	MNF	$20.00
V2499	LT	Variable asphericity lens; other type	MNF	$86.25
V2499	RT	Variable asphericity lens; other type	MNF	$86.25
V2500	LT	Contact lens pmma; spherical per lens	MNF, age 0-20	$16.00
V2500	RT	Contact lens pmma; spherical per lens	MNF, age 0-20	$16.00
V2501	LT	Contact lens pmma; toric or prism ballast per lens	MNF, age 0-20	$39.00
V2501	RT	Contact lens pmma; toric or prism ballast per lens	MNF, age 0-20	$39.00
V2502	LT	Contact lens pmma; bifocal per lens	MNF, age 0-20	$156.00
V2502	RT	Contact lens pmma; bifocal per lens	MNF, age 0-20	$156.00
V2510	LT	Contact lens gas permeable; spherical per lens	MNF, age 0-20	$46.00
V2510	RT	Contact lens gas permeable; spherical per lens	MNF, age 0-20	$46.00
V2511	LT	Contact lens gas permeable; toric prism ballast per lens	MNF, age 0-20	$68.00
V2511	RT	Contact lens gas permeable; toric prism ballast per lens	MNF, age 0-20	$68.00
V2512	LT	Contact lens gas permeable; bifocal per lens	MNF, age 0-20	$176.00
V2512	RT	Contact lens gas permeable; bifocal per lens	MNF, age 0-20	$176.00
V2520	LT	Contact lens hydrophilic; spherical per lens	MNF, age 0-20	$28.00
V2520	RT	Contact lens hydrophilic; spherical per lens	MNF, age 0-20	$28.00
V2521	LT	Contact lens hydrophilic; toric or prism ballast per lens	MNF, age 0-20	$65.00
V2521	RT	Contact lens hydrophilic; toric or prism ballast per lens	MNF, age 0-20	$65.00
V2522	LT	Contact lens hydrophilic; bifocal per lens	MNF, age 0-20	$95.00
V2522	RT	Contact lens hydrophilic; bifocal per lens	MNF, age 0-20	$95.00
V2530	LT	Contact lens, scleral, gas impermeable, per lens	MNF, age 0-20	$66.00
V2530	RT	Contact lens, scleral, gas impermeable, per lens	MNF, age 0-20	$66.00
V2531	LT	Contact lens, scleral, gas permeable, per lens	MNF, age 0-20	$76.00
V2531	RT	Contact lens, scleral, gas permeable, per lens	MNF, age 0-20	$76.00
V2700	LT	Balance lens, per lens	NONE	$37.29
V2700	RT	Balance lens, per lens	NONE	$37.29

OPTICAL SERVICES – NURSING HOME RESIDENTS

Medicaid recipients living in a nursing facility will not experience the service reductions effective September 1, 2005. Nursing facility level of care must be indicated on the Medicaid eligibility file. When providing services to a recipient who is living in a nursing facility, providers should continue to submit claims to Missouri Medicaid in the same way they did prior to September 1, 2005.

Provider Bulletins are available on the DMS Website at http://www.dss.mo.gov/dms/pages/bulletins.htm. Bulletins will remain on the Published Bulletin site only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletin site.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Website at http://dss.missouri.gov/dms/subscribe/MedNewsSubscribe.htm to subscribe to the list serve to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 1-573-635-8908 and using Option One.

Provider Communications Hotline
573-751-2896